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Mr. Chairman and Members of the Committee, my name is Chris Frueh. It is an honor to be here speaking before you and I am grateful for the opportunity to present my views on the use and development of Telemedicine for providing mental health services within the VA. I am a clinical psychologist by training, and I have been a Staff Psychologist with the PTSD Clinical Team at the VA Medical Center in Charleston, South Carolina since 1992. I am also a tenured Associate Professor and Co-Director of the Division of Public Psychiatry within the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina (MUSC).

The President's New Freedom Commission on Mental Health highlighted how people who live in rural areas experience significant disparities in health status and access to care and this includes many veterans. There is currently a significant shortage of qualified mental health service providers in rural and remote areas of the country, including my own state of South Carolina. Today, my testimony will focus on how research evidence that supports the incorporation of telemedicine into clinical practice is being used to guide the development of tele-mental health services, with the specific intent of improving access to care for veterans who are in need of treatment for mental health conditions in Veterans Integrated Service Network (VISN) 7.

VISN 7 constitutes VA's southeast Network and geographically encompasses the states of South Carolina, Georgia, and Alabama. These states have large rural populations. In VISN 7, we face the same challenges VISNs that serve veterans in

predominantly rural states encounter to deliver optimal care to veterans who live in rural areas, and redress the disparities in relation to mental health care that were identified by the President's New Freedom Commission on Mental Health. VISN 7's proactive approach to making services geographically accessible to veterans has included establishing twenty-four community-based outpatient clinics (CBOCs) across the three-state area it serves. The recruitment of qualified mental health professionals, particularly specialist to provide care for substance abuse and post-traumatic stress disorder (PTSD), in rural CBOCs, poses a challenge to VISN 7's strategy of offering locally-based services to meet the mental health care needs of the veterans patients we are privileged to serve.

The opportunities for mental health professionals to hone their clinical skills, receive continuing education, and undertake research upon which their ongoing professional development depends on their desire to continue to provide an excellent level of care that is not currently as readily available in rural locations as it is in more populous areas. A shortage of mental health practitioners in rural areas poses a threat to the long-term strategy of offering comprehensive local access to mental health care in CBOCs throughout our VISN using traditional face-to-face consultations. In 2000 I, and other clinical research colleagues, reviewed the scientific literature to evaluate the evidence in support of using telemedicine to provide mental health clinical services. I have kept abreast of the relevant literature thereafter. In my judgment, the careful application of communications technology has begun to re-shape the conceptual landscape of healthcare. In the mental health field, telemedicine is offering an affordable means of solving longstanding workforce shortage problems and can improve access to care for people in remote geographical areas.

I would like to speak to the dual hypothesis that telemedicine in VHA is relevant to the direct provision of mental health services in rural areas where mental health professionals are in short supply. The same technologies involved in telemedicine can provide distance education and professional development to practitioners who are physically based in these rural areas and thereby offer an incentive for them to remain there. The literature reviews upon which I base my assertions are derived from empirical databases that include Medline, PsycINFO, and Telemedicine Information

Exchange. These reviews, as well as our own experiences in the VA Southeast Network, support the following conclusions:

First and most important, telemedicine services have been shown to lead to improved clinical status. In fact, there is growing evidence that the quality and effectiveness of telemedicine service delivery of mental health care is virtually equivalent to more traditional face-to-face clinical service delivery, and obviously is far superior to the alternative in many rural communities of no mental health care at all. Although more research is needed to help delineate the parameters of how to best provide telemedicine services for mental health, there is little doubt that telemedicine offers a safe, acceptable, and effective mode of delivering mental health services to geographical areas where it is currently lacking.

Second, mental health evaluations, including psychiatric interviews and neuropsychological assessments conducted via telemedicine appear to be accurate and reliable. In other words, most mental health assessments can be conducted with new and existing patients who are at remote locations via telemedicine links. This may even be true for some patients who are suffering the most severe mental disorders or cognitive impairment.

Third, it is clearly feasible to provide both psychotherapy and pharmacotherapy services via telemedicine. The full range of mental health disciplines has the capability of providing their services via this medium. This includes provision of individual and group interventions, including even highly structured, state-of-the-art cognitive-behavioral psychotherapies.

Finally, both patients and clinicians report high levels of satisfaction and acceptance with telemedicine interventions. A therapeutic relationship can be established, even when the patient and clinician never meet face-to-face. Simply put, patients are willing to accept mental health care delivered via telemedicine if it will reduce their travel times and costs, or otherwise provide improved access to care.

Based upon this evidence, VISN 7 is implementing a strategy whereby our VA Medical Centers (VAMCs) will provide support via telemedicine to supplement the mental health care that is currently available in our CBOCs—and in doing so to provide much-needed specialty services, such as treatment of PTSD and substance use disorders. Together with the VISN 7 Network Mental Health Director, and other

colleagues I am involved in developing and implementing a telemedicine training program for mental health clinicians within our Network. So far, we have conducted the initial rounds of this training with VA mental health clinicians in Charleston, as well as the Birmingham VA Medical Center and the Huntsville CBOC in Alabama. Clinicians at the Atlanta VA Medical Center will be the next to receive this training.

VISN 7 is planning how at both the local VAMC and Network levels we can build on our tele-mental health strategy to support the use of telemedicine in providing outreach and educational services to the Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans who are now returning to South Carolina, Georgia, and Alabama. The evidence-based manner in which we are enhancing the mental healthcare services we provide in VISN 7 using telemedicine enables us to coordinate care provision between VAMCs, CBOCs, the Department of Defense, and other local community agencies and adopt a service delivery model aimed at providing all veterans in our Network with access to the clinical services they need.

I believe that our experience in VISN 7 indicates the unique and sophisticated way in which VHA is able to implement a new technology like telemedicine in an evidence-based manner. We are fortunate to have national resources in the form of experts and toolkits that we can draw upon to ensure that clinical, technical and business processes are standardized and mean that we are a part of an emerging national standards-based network that will be interoperable and can benefit from reaching a critical mass that is optimal for the efficient delivery of routine operational services. I and many of my counterparts in VISNs throughout the country, who have affiliations and associations with major academic institutions, can tailor care locally to make sure it is appropriate to the needs of our unique veteran population. We are also undertaking the research required to grow the evidence-base necessary to shape how this care continues to evolve in the future. To do so we are working with such agencies as the Department of Defense, National Institute of Mental Health, Agency for Healthcare Quality and Research, VHA Office of Research and Development and the National Center for PTSD. We are also developing ways in which continuing education and professional development opportunities can be created that can be delivered to our colleagues who wish to remain in practice in rural and remote areas yet concerned about maintaining their contact with centers of clinical excellence.

Mr. Chairman and Members of the Committee, it has been my privilege to discuss my views here before you today. Again, I thank you for this opportunity. I am proud to be involved in the area of healthcare development I have described to you and excited that it promises to address long-standing problems with the delivery of mental health services to veterans in rural America.